THE PSYCHOSOCIAL ADJUSTMENT OF FAMILIES EXPERIENCING INFANT DEATH

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ABSTRACT

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THE PSYCHOSOCIAL ADJUSTMENT OF FAMILIES EXPERIENCING INFANT DEATH

Advisor: Professor Mary Ashong

Thesis dated April, 1988

The purpose of this study was to determine the relationship between age, marital status, income, education family support and the families' psychosocial adjustment following the death of an infant.

The subjects consisted of participants from the support group SHARE, (Source of Helping, Airing, and Resolving Experiences) located at the Link Counseling Center in Sandy Springs, Georgia and Piedmont Hospital in Atlanta, Georgia.

The major findings indicated that there was a significant relationship between age, education, income, family support and psychosocial adjustment following the death of an infant.

DEDICATION AND ACKNOWLEDGMENTS

This thesis is dedicated to my parents, Mr. and Mrs. Sidney O. Nettles for their untiring, unfaltering and unconditional love and support, without which this effort could not have been completed.

The author wishes to express the deepest gratitude to those who helped to make this study a success: SHARE (Source of Helping, Airing and Resolving Experiences), the participants in this study, who at a very stressful period in their lives took time to share their feelings and experiences with me in hopes that they might thereby help those yet to be bereaved.

Sincere appreciation and gratitude is extended to the typist, Mrs. Del Jupiter. A special thanks is extended to Professor Mary Curtis-Ashong for her motivation and guidance.

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CHAPTER I

INTRODUCTION

The death of an infant is a tragedy to a family who is expecting the arrival of their new baby. Coping with the death of an infant is among one of the most difficult problems a family will face. Parents may feel that they are robbed of the future they have planned for the baby. They are plunged into a limbo of private sorrow and emptiness. In today's world of medical miracles, babies are not suppose to die.[1] According to Arnold, the experience of losing a child is special and like no other. The death of an infant is a senseless injustice. An infant's death--whether expected or unexpected, regardless of age and cause is incomprehensible. Family members ache with their own powerlessness and vulnerability and live with emptiness. The family is never whole again because a significant member is missing. When an infant dies, silence often ensues and grows over the years. To speak out about an infant's death is considered unnatural, unwise, too threatening and too painful.[2] Research findings reveal that support groups have

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[1]Rochelle Friedman, Surviving Pregnancy Loss (Boston: Little, Brown & Company, 1982), p. 3.

[2]Joan Arnold, A Child Dies A Portrait of Family Grief (London: System Corporation, 1983) p. 92.

been organized for bereaved parents and siblings to provide information, empathy and comfort at a time when most people do not know what to say.[3] Another reason it is difficult for the family to accept the death of an infant is the fact that the baby's life was short-lived and did not become a reality to the family. As a result of the infant's death, the family is grief-stricken and encounters the five stages of grief. The five stages of grief are denial, anger, bargaining, depression, and acceptance. Every family member may not grieve in this order.[4]

According to Russell, the reaction to death may have a lot to do with one's attitude toward death. Russell also cites Phillippe Aries in the study of Western Attitudes Toward Death; he presents four attitudes toward death found in the history of western civilization. The four attitudes toward death are: (1) resignation to death, (2) acceptance of one's death, (3) fear of and fascination with death, and regarding death as shameful and prohibited.[5] Attitudes toward death is a major indication why people do not like to discuss death. The attitudes still remain today.[6] Death is

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[3]Elizabeth Kubler-Ross, On Children and Death (New York: McMillan Publishing Company, 1983) p. 235.

[4]Ibid., p. 236.

[5]Noreen Russell, Death and Dying (New York: John Wiley and Son, Inc., 1982), p. 2.

[6]Sandra Miller, "Using Images of the Future in Grief Work," Journal of Nursing Scholarship (Spring 1987) p. 2.

a common link between all who have lived, are living, or will live. The authors, Arnold and Gemma make one realize that they are a part of this chain and, as such, are able to help others who experience death before maturity. There is no guarantee for long life, only a lifetime.[7] Social workers can provide treatment to bereaved families that will assist them in their psychosocial adjustment as a result of an infant death. Intervention with the bereaved family will assist them during this unexpected crisis will enable the parents, siblings, grandparents and friends to share their experience, to cope more effectively and assist with the psychosocial adjustment.

Statement of the Problem

Does the death of an infant affect the psychosocial adjustment of the family? Psychosocial adjustment is defined as the cognitive, emotional, and social behavior of individuals based on one's ability to cope with crisis.[8] The word crisis refers to a normal set of stresses and strains rather than to an extraordinary set of events.[9] The grief reaction may be "normal" or "abnormal." A death in the family may cause a dysfunction in the family structure

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[7]Ibid., p. 3.

[8]Newman and Newman, Development through Life, a Psychosocial Approach (Homewood, Ill.: The Dorsey Press, 1979) p. 17.

[9]Ibid., p. 9.

and causes stress to the marital relationship and each member in the family. At the same time, it offers an opportunity for strengthening the ties within the family.[10] Holmes and Rahe conducted a study in 1967 about Life event stressors by utilizing the (SRE) Sectional of Recent Experiences, an instrument that is widely used in research. The (SRE) consisted of a listing of 43 events. People responded to the events by scaling each item that they had experienced recently and in the past. Out of 43 items of life events stresses, the death of a close member of the family ranked number five.[11]

If each mourner recognizes and acknowledges openly what afflicts them and is given permission to share their feelings, the death may bring the family closer together. It is within the context that guidance is needed to help each individual understand and support each other.[12]

Weizman, also believes that death of a child exerts inordinate stress on the marriage. If the marriage has a history of commitment and mutual support, the relationship has a good chance of withstanding the stress. The fact that each partner may have different coping mechanisms, and each

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[10]Irene Josselyn, "The family as a Psychological Unit," Social Case Work, 1953, p. 338.

[11]James H. Johnson, Life Events as Stressors in Childhood and Adolescence (California: Shage Publishing Company, 1986), p. 24.

[12]Savine Weizmar, About Mourning (New York: Human Science Press, Inc., 1985) p. 42.

goes through the phase of grief at a different pace may disrupt the marriage.[13]

Sometimes couples try to protect each other, but by doing so they deprive themselves and others of comfort. Husbands and wives must help each other express grief. It is a reciprocal process. A member of the family may fall into a pattern of stoic behavior because of social cultural expectations or to appear strong and reliable to their spouse. Sometimes it is their own inability or unwillingness to express emotions. This behavior may be perceived as unfeeling and uncaring. Rather than being supportive it is distancing behavior. The partner feels as if the other does not hurt deeply and feels isolated.[14] In view of the need for more specific knowledge concerning particular forms of bereavement and the central role of social workers in providing psychosocial service to individuals and families facing the loss of an infant, this paper will review research findings on bereavement following a child's death. Findings from empirical literature, social work, psychology, psychiatry, nursing, sociology and pediatrics will be reviewed, and implications for social work practice will be developed.

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[13]Ibid., p. 43.

[14]Nancy Berezin, After a Loss in Pregnancy, New York: Simon and Schuster, 1982), p. 11.

Statement of Hypothesis

1. Ho: There is no significant relationship between psychosocial adjustment and age.

   Ha: There is a significant relationship between psychosocial adjustment and age.

2. Ho: There is no significant relationship between psychosocial adjustment and marital status.

   Ha: There is a significant relationship between psychosocial adjustment and marital status.

3. Ho: There is no significant relationship between psychosocial adjustment and income.

   Ha: There is a significant relationship between psychosocial adjustment and income.

4. Ho: There is no significant relationship between psychosocial adjustment and education.

   Ha: There is a significant relationship between psychosocial adjustment and education.

5. Ho: There is no significant relationship between psychosocial adjustment and family support.

   Ha: There is a significant relationship between psychosocial adjustment and family support.

Purpose of the Study

The purpose of this study is to examine the psychosocial adjustment of families experiencing an infant death based on: age, income, educational level, marital status, family functioning and support, and their decision to join a support group. The objectives are: (1) to examine the family functioning and support, (2) to focus on symptoms of grief as it affects the psychosocial adjustment of the family, (3) to investigate the impact upon the various subsystem, of the family, such as the parents,

siblings, grandparents and friends, (4) to evaluate group therapy and individual therapy with the families and (5) to evaluate crisis intervention theory and system theory.

Limitations

The study was limited to families who participated in the support group SHARE (Source of Helping, Airing, and Resolving Experiences).

CHAPTER II

REVIEW OF LITERATURE

Historical Perspective of Infant Mortality

An Obstetrician's View

Throughout history pregnancy has demanded its toll of the mother, her unborn child, and newborn baby. It seems incredible that just eighty years ago in this country, for every hundred deliveries, one mother died and ten babies did not survive to their first birthday. This century has seen dramatic progress in the reduction of mortality. The risk of maternal death is now one one-hundredth of what it was in 1900 and infant mortality is one-tenth of the rate at that time. Falling rates, however, can bring little comfort to the families whose babies die and thus become statistics. Indeed, the grief does have an effect on the family today. Whereas, in the "bygone era", the frequency of death had some effect in lessening its impact.[15]

Nancy Berezins' book analyzes the sensitivity of many issues that surround unsuccessful pregnancies. Yet, to the mother, it represents a baby who will never be. This undoubtedly is one area in which there has been poor

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[15]Ibid., p. 12.

communication between health professionals and the patient, with inadequate consideration of the grief by the mother.[16]

From the obstetrician's view, the women interviewed by Berezin, discovered that women rarely turn to their physicians for comfort. The obstetrician is rarely identified as a source of support and comfort. In practice, one sees many examples of patients who reject their former physicians and turn to another when they become pregnant again after an unsuccessful pregnancy. Superstition, guilt, anger, shame, unpleasant memories, and disappointment must all feature in such a rejection.[17]

Traditionally, the medical profession has not dealt well with the grief-stricken patient. Perhaps the obstetrician, in what is generally considered to be a happy specialty, is even less well-prepared than others to adequately console a patient at the time of great sorrow. The dialogue between a crazed patient and the physician is often artificial and strained. In part to mask the anguish of failure, the physician tends to respond tearlessly in a manner he perceives as professional. The stiff upper lip becomes a mask.[18] This is the primary reason that social work intervention with the family is needed, the doctor and

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[16]Ibid., p. 12.

[17]Ibid., p. 13.

[18]Ibid.

nurse may not provide the necessary social/psychological support for the family during this time of crisis.

It is clear that families who have suffered the loss of a loved one require both social and emotional support. Grief comes under scientific scrutiny, and the mourning process has been classified and analyzed, for every family bears a unique and individual sorrow. Time may modify the pain and the grief; but to some extent, the scar will remain forever. The scar may be great or small.[19] Therefore, obstetricians should offer compassion and help in the earliest phases of the healing process after the death of the infant along with the social worker's interaction with the family.

Recognized by the arts as a unique and perhaps most devastating loss, the death of a child has been the subject of an expanding body of research.[20] An interdisciplinary committee that was recently commissioned by the National Institute of Mental Health recognized the need for more specific knowledge concerning unique forms of bereavement and also recognized the continuing role of health professionals in providing services to the bereaved.[21] The

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[19]Joan Arnold, A Child Dies A Portrait of Family Grief (London: Aspen System Corporation, 1983), p. 90.

[20]M. Osterweis, Bereavement: Reactions, Consequences and Care (Washington D.C.: National Academy Press, 1984), p.224.

[21]Ibid., p.225.

report states that "the social worker's role is to maintain and enhance family solidarity at the time of crisis."[22] In addition to the role of social workers in hospital and health clinic settings, social workers are the primary providers of professional mental health services in this country, provide counseling services to people who are suffering from long-term effect of loss.[23]

In view of the need and specific knowledge about bereavement and the role of the social workers in providing psychosocial service to individuals and families facing the loss of a child, the following material is a review of research findings on bereavement following a child's death. Empirical literature from social work, psychology, psychiatry, nursing, sociology, and pediatrics will be reviewed.

The Uniqueness of Parental Bereavement

Empirical and clinical literature demonstrate that parental bereavement is a distinct form of bereavement that has serious long-term psychosocial consequences. This section highlights some areas that are affected by the death of a child.

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[22]D. Goleman, "Social Workers Vault into a Leading Role in Pychotherapy," New York Times (April 30, 1985), p. 12.

[23]M.A. Lieberman and L. Borman, Self Help Groups for Coping with Crisis (San Francisco: Jossey-Bass, Inc., 1979), p.30.

Mental Health

Videka-Sherman and Lieberman found that bereaved parents were highly distressed on mental health indicators such as depression, anxiety, somatic symptoms, self-esteem, and sense of control in life when compared to a control sample of non-bereaved parents who were matched for age, race, gender, and educational attainment. Furthermore, the same author found that there was little evidence that parents' mental health status improved one year later. In the sample that was composed of 390 bereaved parents from eighteen geographical areas across the United States and Canada, parents had lost children from a variety of causes, including long-term and Sudden Infant Death Syndrome, miscarriage and stillborn.[24]

A number of other studies have also documented deleterious psychosocial consequences for parents when a child dies. Roskin found that bereaved parents indicated less emotional health than did controlled parents.[25] Clyman found that eighty percent of their sample of parents who had experienced the death of a newborn felt that they needed some ongoing intervention because of their perceived

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[24]Lynn Videka-Sherman, "Research on the Effect of Parental Bereavement: Implication for Social Work Intervention" Social Service Review (March, 1987), p. 10.

[25]M. Roskin, "Emotional Reaction Among Bereaved Isreali Parents," Israeli Journal of Psychiatry and Related Science (1984), p. 73.

"inability to resume previous responsibilities."[26] Payne, Goff, and Paulson found that parents continued to report "nerves on edge" (67%)," preoccupation with thoughts of the child" (73%), and "feelings of anger" (60%) years after their children had died.[27] Nixon and Pearn, in a comparative study of families who almost had a miscarriage with families who did have a miscarriage, found that families whose children died, demonstrated poorer psychosocial functioning.[28] Sanders found that the death of a child was more distressing than was the death of a parent or spouse.[29] Binger found that eleven of twenty-three families experienced severe adjustment difficulties after a child died of Sudden Infant Death Syndrome.[30]

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[26]R. Clyman, "Issues Concerning Parents After the Death of Their Newborn," Critical Care Medicine (1980) p. 215.

[27]J. S. Payne, "Psychosocial Adjustment of Families Following the Death of a Child," The Premature Infant (Springfield, Ill.: Charles C. Thomas, 1980), p. 50.

[28]J. Nixon and J. Pearn, "Emotional Sequelae of Parents and Sibs following the Miscarriage of Near Miscarriage of an Infant" Australian and New Zealand Journal of Psychiatry (1977) p. 265.

[29]C. Sanders, "A Comparison of Adult Bereavement in the Death of a Spouse, Child and Parent," Omega 10 (1979-80) p. 303.

[30]C.M. Binger, "Sudden Infant Death Syndrome: Emotional Impact on the Family," New England Journal of Medicine 280 (February 20, 1982) p. 414.

Marriage Quality

The marital relationship is particularly vulnerable after a child dies. On several measures of marriage quality Videka-Sherman and Lieberman found levels of distress of bereaved parents much higher than in a matched non-bereaved sample.[31] Furthermore, all indicators of marital happiness deteriorated over time, although the study found no evidence of divorce rate of bereaved parents approached the 80 percent level, a figure reported by Schiff.[32] Nixon and Pearn found the separation rate to be 24 percent in parents who had miscarriages and zero percent in parents of children who nearly had a miscarriage.[33]

Sherman studied sixty-four spouse pairs after a child died from a wide variety of causes.[34] He found that husbands and wives coped differently with grief. Women reported using more coping strategies of all types. Women also reported poorer marriage quality than did their husbands. Even families with previously strong and stable

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[31]L. Videka-Sherman, "Research on the Effect of Parental Bereavement: Implication for Social Work Intervention," p. 3.

[32]H.S. Schiff, The Bereaved Parent (New York: Crown Press, 1977) p. 57.

[33]Nixon and Pearn, "Emotional Sequelae of Parents and Sibs Following the Miscarriage of Near Miscarriage of an Infant" Australian and New Zealand Journal of Psychiatry 11 (1977) p. 267.

[34]B. Sherman, Parental Bereavement and Marriage (Ph.D. dissertation, University of Chicago, 1982) p. 35.

relationships described strain caused by the loss and individual spouses' grief reactions. Marital strain was pronounced when spouses reacted differently to the child's death. For example, fathers sometimes took refuge in their work and preferred not to dwell on the loss, while mothers wanted to talk about the child and to express their pain through crying. An unexpressive grieving style results in emotional unavailability to the expressive spouse and may add to the burden of expressive grief.[35]

Identity Changes

Sherman explained that despite the levels of distress reported by bereaved parents on standard mental health and marriage-quality instruments, many parents describe positive aspects of "surviving" the loss. In the Self-Help Project, forty-nine percent of the parents reported that their grief experience resulted in some positive changes that can be described as personal growth.[36] Changes in values that were most frequently cited included becoming less materialistic and increasingly valuing interpersonal relationship, especially among family members as opposed to other things in life such as career or personal goals. Another frequently stated personal change was recognition of

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[35]Nixon and Pearn, "Emotional Sequelae of Parents and Sibs Following the Miscarriage of Near Miscarriage of an Infant," p. 268.

[36]Videka-Sherman, "Research on the Effect of Parental Bereavement: Implication for Social Work Intervention," p. 5.

formerly unrealized adaptive potential. Futterman and Hoffman obtained similar findings in a qualitative study of bereaved parents.[37] They found an increased capacity for empathy and intimacy and a tendency to become more present oriented, that is, to savor the present.

Futtermans' and Hoffmans' study found that many parents (64%) also reported personality changes six years after their children died.[38] The personality changes that most parents reported included becoming more tolerant and caring of others.

What is notable concerning these dimensions of personal change is that they are relatively independent of traditional mental health measures. At the same time that parents experience extreme psychosocial distress, they also report that they have grown in positive directions setting and implementing clearer priorities in life.

Predictors of Adaptation

In addition to revealing the magnitude and nature of the effect of parental bereavement, research revealed characteristics that are associated with adaptation. While the personal and family devastation following a child's death is ubiquitous, considerable variation occurs in

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[37]E.H. Futterman and I. Hoffman, "Crisis and Adaptation in Families of Sudden Infant Death Syndrome," The Children and His Family (New York: John Wiley & Son 1973) p. 30.

[38]Ibid., p.31.

bereaved parents' adaptation. This section will highlight research findings on parent's adaptation following a child's death. Predictors of adaptation can be conceptualized as person or situation characteristics.

Circumstances of the Loss Situation

Most of the empirical work on parental bereavement focuses on parents of children who die of illnesses of some duration, such as childhood cancer, or on children of a particular age group such as neonates. Comparative studies of bereavement following the deaths of children of different ages who have died of different causes are rare. The Self-Help Project investigated circumstances of the child's death as predictors of parents' adjustment at one and two years after the child's death. The circumstances of the loss included the passage of time after the death, the age of the child, the cause of the child's death, and whether there were surviving siblings. Some of these variables predicted differences in parents adaptation.

Passage of Time After the Death

The passage of time alone does not clearly map recovery for bereaved parents. Videka-Sherman, Liberman, Spinetta, Searner, and Sheposh found that bereaved parents remained substantially more distressed than did a comparable sample of non-bereaved parents and that mental health and marital adjustment showed variable rates of recovery as time passed.

These parents experienced intense symptoms of grief for a much longer time than that predicted by many theories of grief. Rando in a study of parents whose infants died of Sudden Infant Death Syndrome, found that grief intensified over time.[39] Similar findings were reported by Levav.[40] Edelstein also found that the passage of time is not a reliable predictor of adjustment following the death of a child.[41] Time alone is not the great healer for bereaved parents.

Causes of Infant Death

The cause of the child's death was a potent predictor of parents' depression and personal growth at one and at two years post loss.[42] Parents who lose an infant often want an explanation as to why the baby died. Some of the major causes of infant death are explained.

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[39]T. Rando, "An Investigation of Grief and Adaptation in Parents Whose Children Have Died From SIDS", Journal of Pediatric Psychology 9 (1983) p. 3.

[40]I. Levav, "Mortality and Psychopathology Following The Death of Child: An Epidemiological Review," Israeli Journal of Psychiatry and Related Sciences 20 (1982) p.23.

[41]L. Edelstein, Maternal Bereavement (New York: Praeger Publisher, 1984), p. 32.

[42]Videka-Sherman,"Research on the Effect of Parental Bereavement: Implication for Social Work Intervention," (March 1987) p. 3.

Blood Type Incompatibility

Controversy exists about whether blood type incompatibility of either Rh or ABO system in the parents increase the likelihood that early miscarriage will occur. Blood group incompatibility, however, has clearly been demonstrated to contribute to the loss of pregnancy after twenty weeks.[43]

DES Exposure

Diethylstilbestrol (DES), a synthetic estrogen was first used as a medication to prevent fetal loss in 1945. It was used for this purpose until 1971, when an association was discovered between DES exposure and a rare form of vaginal cancer in the daughters of women who had been treated. The discovery that DES exposure was also associated with unusual but characteristic abnormalities of the vagina and cervix among the daughters of those treated with DES. Although it was originally feared that these vaginal and cervical abnormalities might be associated with the later development of vaginal cancer, this concern appeared not to have been borne out. Happily, the overall incidence of vaginal cancer in DES daughters was also much lower than was originally predicted.[44]

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[43]Rochelle Friedman, Surviving Pregnancy Loss (Boston: Little & Brown Company, 1982), p. 42.

[44]Ibid.

In recent years DES exposure has been linked to a variety of fertility problems. Clinical studies have indicated that women whose mother took DES show a somewhat reduced ability to conceive, compared to the overall population. DES exposure has also been held responsible for a higher than usual incidence of tubal pregnancy. Although as yet the association between DES exposure and both miscarriage and prematurity has not been conclusively established, there is evidence to indicate the women exposed to DES have a higher than average incidence of uterine abnormalities, cervical incompetence, first and second trimester, and premature births.[45]

Maternal Disease

An increased rate of fetal loss (miscarriage and stillbirth) has been linked with a number of infectious diseases.[46]

Some viral agents are thought to be responsible for both congenital malformations and miscarriage. A higher than normal incident of both types of difficulty are found in women infected with the following viruses: rubella (German measles), cytomegalovirus, herpes simplex virus, measles, mumps, polio, chicken pox, and hepatitis.

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[45]Ibid.

[46]Ibid., p. 43.

Fortunately, these infections tend to be quite uncommon during pregnancy.[47]

T mycoplasma, an infectious agent that has characteristics of both bacteria and viruses, has been found in the tissue of some aborted fetuses. This microorganism has been implicated as a cause of both infertility and of miscarriage. While research studies have not definitively demonstrated that T mycroplasma causes either infertility or miscarriage, since both tests to isolate this agent from the parents and antibiotic treatment are easily obtained and without risk, many physicians treat couples whose cultures are positive. When a positive culture is obtained, both parents are treated with a course of antibiotics prior to attempting another pregnancy.[48]

The risk of miscarrying is somewhat increased for women who have certain chronic illnesses. This is particularly true when the illness is severe. Diabetes, systemic lupus erythematosis, some heart conditions, kidney disease, and markedly elevated blood pressure, are all associated with an increased rate of miscarriage.[49]

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[47]Ibid.

[48]Ibid.

[49]Ibid.

Radiation Exposure

Exposure to significant amounts of ionizing radiation has been linked with both an increased incidence of miscarriage and an increased incidence of congenital malformations. Exposure to all types of x-rays should be avoided during pregnancy unless absolutely necessary. If at all possible, ultrasound, which uses high-frequency sound waves, should be used in preference to diagnostic x-ray during pregnancy.[50]

Malnutrition

Poor nutritution has been implicated in many complications of pregnancy, the rate of vitamin and protein deficiency in causing miscarriage has been conclusively proven.[51]

Maternal Age

The risk of fetal loss of all types, including miscarriage, is significantly greater for women under the age of twenty and over thirty-five than for women between these ages. Why this is so is not known.[52]

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[50]Ibid.

[51]Ibid.

[52]Ibid., p. 44.

Use of Alcohol

The Surgeon General's Advisory on Alcohol and Pregnancy warns that alcohol consumption during pregnancy, especially during the early months has been demonstrated to be harmful to the fetus. An increase in the rate of miscarriage is one of several hazards associated with alcohol use during pregnancy. Women who consume one ounce of obsolute alcohol twice a week have been reported to experience a significantly increased rate of miscarriage. The effect of lower levels of alcohol consumption or less frequent use carries an, as yet unknown risk, as no absolutely safe level of alcohol consumption has been established.[53]

Use of Marijuana

The American Medical Association has officially labeled marijuana a dangerous drug. Marijuana use has been demonstrated to affect reproductive function adversely in a variety of ways, including increasing the likelihood that miscarriage occurs. In a study in which female monkeys were treated with THC, the active chemical in marijuana, for three to five years at doses comparable to daily consumption for humans, the miscarriage rate was found to increase significantly.[54]

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[53]Ibid.

[54]Ibid.

Use of Tobacco

Smoking has been implicated in increasing the risk of miscarriage. Although all the evidence is not yet in, it seems advisable that cigarette smoking should be stopped during pregnancy.[55]

Use of Caffeine

There is evidence to indicate that the consumption of caffeine during pregnancy is associated with an increase in the incidence of miscarriage. It is advised that beverages such as coffee, tea, colas and drugs containing caffeine be eliminated from use during pregnancy.[56]

Trauma

Only in extremely rare instances are either physical or emotional traumas thought to be responsible for causing miscarriage. Travel by car, train, or plane has not been associated with an increased incidence of miscarriage. Similarly, most pregnant women can work, exercise in moderation without jeopardizing either themselves or the fetus. The reason for this is that the fetus is well protected.[57]

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[55]Ibid.

[56]Ibid.

[57]Ibid., p. 45.

Environmental Factors

Exposure to pesticides and other toxic chemicals should be avoided during pregnancy, as evidence is accumulating to indicate the harmful effect of many of these substances on the developing fetus.[58]

Families are always seeking to find a tangible reason why the pregnancy failed. Frequently, none is found. Most couples have a great deal of difficulty dealing with this uncertainty. Every event or occurrence is scrutinized in an attempt to find an explanantion for the unexplainable. Therefore many couples feel that a cause must be found before the loss of the infant can be put behind them.[59]

Social Class and Ethnic Differences

A glaring gap in the research on parental bereavement is the lack of attention to class and ethnic differences in the grieving process, despite the many studies indicating that class and ethnicity are important factors to consider in other forms of bereavement.[60] Roskin's study of Israeli bereaved parents is the only study to investigate effects of

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[58]Ibid.

[59]Ibid.

[60]M. Osterweis, Bereavement: Reactions, Consequences and Care (Washington D.C.: National Academy Press, 1984), p. 225.

social class.[61] He found the social class was inversely related to distress five years after the child's death. Less well-to-do parents were more vulnerable to higher levels of distress. No studies could be located that investigate the effects of ethnicity on bereaved parents' experiences.

Parents Coping Strategies

Research indicates that certain coping responses are more adaptive than are others and that factors that predict adjustment to a life-threatening situation to the infant are not necessarily those that predict adjustment after the child has died. Likewise, coping strategies that predict parents' own mental health are not necessarily the same as those that predict marriage quality.

Research findings suggest that, when a child is dying, there are several coping strategies that a parent can use to promote personal adjustment to the child's ultimate death. These include: maintaining a consistent set of values concerning the meaning of life; having available and using the support of others, particularly one's spouse; and communicating openly and fully to the child, including discussion of the cause of death.[62] A moderate amount of

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[61]M. Roskin, "Emotional Reaction Among Bereaved Israeli Parents," Israeli Journal of Psychiatry and Related Sciences (1984), p. 74.

[62]Ibid, p. 78.

anticipatory grief, when the death is foreseeable, promotes adjustment before and after the child's death.[63]

Videka-Sherman found that after the child's death, from whatever cause, constructive actions to seek new fulfillment in life predicted positive adjustment overtime.[64] "Constructive action" took a variety of forms, such as having a new child or investing extra energy in surviving children, making a valued career change, or becoming engaged in an altruistic endeavor such as taking on a "helper" role in a self-help group like SHARE (Source of Helping, Airing, Resolving Experiences).[65]

Other coping strategies predicted poor post-loss adjustment. Efforts to escape from the pain of the loss by consciously trying to rid oneself of painful thoughts or by use of psychotropic medication or alcohol were costly to the parents in terms of mental health and marriage quality.[66] The same study found that expressiveness in grieving and religiousness did not predict adaptation differences.

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[63]T.Rando, "An Investigation of Grief and Adaptation in Parents Whose Infant Died of SEDS" Journal of Pediatric Psychology 8 (1983) p. 12.

[64]L. Videka-Sherman, "Coping with the Death of a Child, A Study Overtime" American Journal of Orthopsychiatry 52 (October 1982) p. 13.

[65]P. Chodoff "Stress Defenses and Coping Behavior: Observations and Parents Who Experienced anInfant Death," American Journal of Psychiatry 150 (1964) p. 743.

[66]Ibid.

In the marital domain, Sherman found the women were more sensitive and reactive to how their spouses coped with the loss than men.[67] Three studies reviewed showed that husbands' active involvement in the child's death and expressiveness in terms of feelings about the loss predicted better assessment of marriage quality on wives' part.[68]

The Effectiveness of Professional and Informal Helper

Who provides effective help to bereaved parents? While there has been evidence of the contribution of family and friends to positive adjustment to other types of bereavement, there are few studies of professional or non-professional help for bereaved parents.[69] Binger found that social workers were perceived as an important source of support to parents who have lost an infant.[70] Several researchers have noted that parents provide important support to one another.[71]

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[67]Videka-Sherman, "Coping with the Death of a Child, A Study Overtime," p. 15.

[68]Ibid., p. 16.

[69]Ibid.

[70]C.M. Binger, "Sudden Infant Death Syndrome: Emotional Impact on the Family," New England Journal of Medicine (February 1983), p. 416.

71K. Walker, "Social Support Network and the Crisis Bereavement," Social Science Medicine (1977) p. 35.

Social Workers' Roles with Bereaved Parents

The social worker in the health care setting has a unique opportunity to assist parents who have had infants to die. Research on parental bereavement indicated that a moderate amount of anticipatory grief was adaptive for parents in terms of helping them to adjust to the death of the infant. Social workers in the health setting can facilitate anticipatory grief in several ways. One study showed, when social workers repeated information about the infant's cause of death and explored psychosocial concerns, parents retained more accurate information about the cause of death, which enabled them to cooperate with medical treatment and talk more openly about the situation.[72] This translates into two principles for the social worker, namely, that the social worker be knowledgeable about the cause of the infant's death and be able tp discuss it with the family. Good working relationship with physicians and nurses and participation in team meetings are needed to stay abreast with the condition of the child. In this way, the social worker can openly talk to the parents about the medical treatment and conditions of the child which sets the stage for the development of a close working relationship with the family. With this relationship as a base, the practitioner is in credible position to support parents as they struggle

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[72]S. Blatterbauer, "Enhancing the Relationship," Health and Social Work (February 1976), p. 45.

with balancing hope for recovery and to support them after the child dies. Social workers should assist parents in dealing with feelings of guilt if they begin to sense they are losing the child. It is important to facilitate anticipatory grief. Many parents reported that they were not conscious of "preparing" for the child's death.[73]

Another important role for the social worker is to identify parents who may be at especially high risk for poor adjustment and to develop services for them. The research reviewed in this article suggest that several groups of parents are especially high risk for difficulties in adjustment after a child dies. These are parents who lost their infant during the last trimester of pregnancy. When a child dies suddenly, parents often have only "fleeting" contact with health care providers, usually in an emergency room. While many hospital social workers services provide crisis intervention with the families, the long-term high-risk status for these parents suggest that additional services could benefit them, such as support groups. One model that was suggested by Videka-Sherman is to implement a regular follow-up contact with parents two to three months

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[73]Ibid.

after the loss had occurred.[74] The contact would be made for two purposes: to assess how well the family is adjusting and to provide or refer the family for additional service if needed. The time frame suggested for the follow-up emanates from a statement made by many bereaved parents that it is after the time of the funeral, six weeks to three months after the return to their own lives, leaving the bereaved parent to feel abandoned by the child, friends, and family. By this time, family and friends often give implicit and explicit messages to the parent to "snap out of it". Assessment of parents' adjustment can be made by discussing the parents' ability to fulfill role responsibilities at work and at home, the quality of their interpersonal relationships and their level of psychological distress. If given the opportunity, most parents who are experiencing greater distress will self-select into professional or self-help treatment.[75] Therefore, linking parents to helping resources may be a critical enabling factor for parents to obtain needed help. One problem with the health care-financing system in the United States is that this type of post loss service is not reimbursable, making it infeasible for social workers in some settings to offer it.[76] While

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[74]L. Videka-Sherman, "Coping with the Death of a Child, a Study Overtime," American Journal of Orthopsychiatry 52 (October 1982), p. 15.

[75]Ibid.

[76]Ibid.

this may be the case in many health organizations, the social worker could, at minimum, make a follow-up contact and refer parents to other community resources such as community mental health centers or self-help organizations such as SHARE.[77]

The final implication from the body of research has to do with how practitioners can encourage parents to cope adaptively with grief. Professionals should explain to parents that the myth about becoming pregnant soon after the death of a child, means that the parents have not grieved effectively. There is no evidence that a new pregnancy has any negative effect on the family in the second year of post loss period.[78]

Social workers can facilitate opportunities for altruistic expression by supporting and consulting with self-help groups and by structuring volunteer programs for hospital pediatric service. Social workers should encourage altruistic activity since there is evidence that both the giver and the receiver of altruistic help benefit, a phenomenon that Reissman named the "helper therapy" principle.[79] One coping response that social workers should be careful not to thwart is open expression of grief at any

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[77]Ibid.

[78]Ibid.

[79]F. Reissman, "The `Helper' Therapy Principle," Social Work 10(April 1965) p. 27.

point in the first two years post bereavement. The expressions, such as crying, talking about the child or thinking about the child, was not associated with negative outcomes. Bereaved parents most frequent complaint about family, friends, and professionals alike is that others are intolerant of grief being expressed after the time of the funeral.[80]

This review of literature has attempted to summarize the growing literature concerning the psychosocial adjustment of the family and the development of the social workers' roles for clinical intervention. There is growing evidence that parental bereavement is a unique form of bereavement that has a long-term effect on the surviving parents, and there are personal and situational factors that affect the parents' course of grief. Social workers are key professionals who help these parents.

The sibling rivalry of the deceased infant is sometimes forgotten. The siblings also go through a period of bereavement. Most of the scarce literature on the bereaved child addresses the child's reactions to a death. Information is basically missing about what the counselor with the bereaved child could be doing and the special preparation needed. Thus, one article concentrates on the counselor in such a situation with the goal of introducing

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[80]Mary Elizabeth Taylor Warmbrod, "Counseling Bereaved Children: Stage in the Process," The Journal of Contemporary Social Work (June 1986) p. 354.

some guidelines for grief work with children. After the context in which the guidelines apply is discussed, the rationale for conjoint session with the bereaved child's family is provided, followed by an identification of personal qualities of the knowledge base needed to be a counselor with a bereaved child.[81]

The conceptualization of the process of counseling with those in grief, is organized into three more or less distinct stages that have been developed and refined over the course of the Warmbrod's work with children in grief. A different aspect of the family's life is the focus in each of the three stages. A therapeutic assessment of the bereaved, proposed by Beverly Raphael, although not focused on children, covers these stages in the same order, confirming the importance for bereaved children and their remaining parents and grandparents to consider in order those three aspects of their life together.[82]

Examples as to what the counselor might say and do to facilitate the child's sharing the experience are given. A sense of direction and of the areas yet to be covered is provided for the counselor who knows these stages, the kinds

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[81]Ibid.

[82]Beverly Raphael, The Anatomy of Bereavement (New York: Basic Books, 1983), p. 150.

of questions appropriate for each stage, and frequent responses of the parent and child at each point.

In each of the three stages, the focus is on the different aspects of the family's life. First there is the focus on the death and the funeral of the loved one with its accompanying responses. The second stage considers what the dead person was like, what the family did together, and, naturally, what about the dead person is missed. That leads to the third stage, in which the discussion turns to the present with reference to when the person is missed, adjustment finished and forthcomings, and source of comfort. It can be considered that the first stage is the recent past and major event, with the second stage moving back further in time so that, in the third stage, the family members can recognize what they have in the present as they move forward into the future without denying the past.[83]

Systems Theory/Crisis Intervention Theory

When the counselor is working with the bereaved family, the counselor should look at the total functioning of the family based on systems theory. The family has other systems that impact on them during the time of crisis (infant death). The elements of these systems are: society, the extended family, friends, co-workers, and the church. The key concepts of general systems theory are: wholeness,

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[83]Ibid.

relationship, and homeostasis.[84] The family system may become imbalanced when a death occurs; therefore, counseling might be needed to maintain the balance at the time of crisis.[85] Minunchin describes boundary restructuring as a therapeutic intervention in enmeshed families which allows differentiation and more efficient family functioning.

Systems theorists conceptualize families as comprised of various subsystems. Intervention can be directed toward a specific subsystem, since change at any level is assumed to affect the family's overall functioning.[86]

This leads into the discussion about crisis intervention with families experiencing an infant death. Crisis intervention postulates that a crisis situation such as death disrupts the levels of functioning of the each family member. The mangeable internal psychological difficulties are disrupted.[87] Crisis intervention views the emotional disturbance presented by people facing crises as being the result of: (1) the stressful situation which a person faces, and (2) underlying emotional dispositions which only come to the surface in crisis situations.[88]

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[84]Charles Zastrow, The Practice of Social Work (Homewood Ill.: Parsey Press, 1985), p. 229.

[85]Ibid.

[86]Salvador Minuchin, Families and Family Therapy (Cambridge, Mass.: Harvard University Press, 1974), p. 56.

[87]Zastrow, The Practice of Social Work, p. 466.

[88]Ibid.

Crisis intervention postulates that underlying emotional difficulties are ingredients of all personalities. People are viewed as being fairly normal in their general adjustment, with crisis being a major cause of a person's emotional difficulties.

Crisis intervention postulates at the point of the crisis a person is most vulnerable to change, and therefore, it is at this point that services are most needed and have the highest probability of having a positive effect.[89] As a result, the social workers' roles are very important and crucial during the onset of a crisis because the family needs someone who can support, consult and advocate for them. The social worker in a hospital setting may support the bereaved family by providing information to the family about cause of death and assisting the family to make arrangements for the burial of the baby.

Support Groups for the Bereaved

Mourning the loss of a loved one involves a complex series of behavioral and psychosocial elements. Feelings of emptiness, sadness, fearfulness, apathy, self-doubt, and loss of sexual drive are common.[90] The following paragraphs will describe bereavement groups that were designed to help

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[89]Bernard Schoenberg, Bereavement Its Psychosocial Aspect (New York: Columbia University Press, 1975), p. 367.

[90]Philip Roy, "Group Support for the Recently Bereaved,"Health and Social Work (July 1983), p. 230.

the bereaved to cope with these problems. The four themes of the support group will be described along with the group process.

Bereavement groups were formed as part of the service because the period of grief contains an elevated risk of morbidity and mortality, and groups are an effective way of meeting the need of the bereaved as they struggle to cope with their losses through the group process.[91]

The three most common support groups for families who have lost an infant are SHARE, AMEND, and Compassionate Friends. The leader of these groups are usually people who have lost an infant themselves. SHARE, the group that participated in this study, is an open group in which members can enter at any time, and meetings are held once a month. The families are usually referred to the group by hospital staff, the social worker, doctor, nurse, or chaplain.

The husband is encouraged to attend the group session, and these sessions are called the couples' group. Those members who cannot attend the group usually communicate to SHARE via the phone and receive assistance from a SHARE member.

The four important discussion themes of the group will be described. The first theme has to do with time, and the most frequent time-related discussion topic is the

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[91]Ibid, p. 231.

questioning by group members about the appropriate duration of bereavement. Another discussion topic related to this theme is the importance of anniversaries, holidays, and other events.[92]

The second theme is the emotional state of members. Discussion involving this theme may take the form of general conversational exchanges about the need to talk, the effort to sort out healthy from unhealthy responses, or the variability of emotions, including setbacks to adjustment. It is as if the painful feeling has led to the need to reassess the appropriateness of emotion in the members' lives. Members also attend to specific emotional expressions, such as crying, and share experiences they have had with waves of sadness that often arise without warning. Loneliness, lack of physical contact with others, hallucinations, fearfulness, and ambivalence about visits to cemeteries are commonly expressed concerns of group members who often review the last days of the deceased, expressing guilt over what they feel they neglected at that time or satisfaction over good moments of sharing and closeness before death.[93]

The third theme centers on family problems. The bereaved talk about the conflict in their households, noting the myth that death brings families closer together. They

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[92]Ibid., p. 232.

[93]Ibid.

also talk about lack of support. Many group members complain that their families criticize them for attending the group. Relatives will say, "Why do you belong to a bereavement group? "That's just wallowing in self-pity," or "The group just makes things worse." Members also share their reactions to unhelpful comments made by family and friends. For example, group members nearly always react with anger to "I know just how you feel."[94]

The fourth theme is the significance of social roles. Frequently, this will include talking about changes in the sense of identity of members, especially if they have had a major shift in their occupational or financial status. Members also examine their roles in relation to the group, that led them to volunteer to help those in more recent stages of grief. This aids in the shift from the role of the griever to the supporter of the grieving members.[95]

Beneficial Results

Yalom described a number of helpful factors that emerge in therapy groups. For instance, when those attending the group are not all in the same stage of bereavement, the group functions to instill hope in those who are in an earlier or more difficult stage and allow those in later stages to see how they have grown. Also, the sharing of

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[94]Ibid.

[95]Ibid., p. 233.

feelings leads group participants to learn not only that they are not alone in their reactions but also gives these members the idea that there is something they can do to help others. This kind of sharing allows members to risk the expression of painful feelings by helping other members through their pain. This expression is a corrective emotional experience, because the members discover the group's acceptance of such feelings.[96]

The nature of the pattern of attendance makes cohesiveness difficult, at least in the strictest sense, but the common bond of the members leads to a feeling of unity and acceptance. One reason for this feeling is that leaders and members alike serve as instructors and provide information about a variety of issues associated with losing an infant. Finally, the members benefit from discussion of existential factors concerning loss and how their loss may have helped them to understand what is important in their own lives.[97]

Research on the effectiveness of bereavement groups in preventing pathological grief reactions has yielded mixed conclusions, as in the following three examples. Williams and Polak found that crisis intervention did not decrease the risk of physical illness, psychiatric illness, or social

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[96]Ibid.

[97]Ibid.

disturbance in families of the deceased.[98] Jones found no statistically significant differences between treatment groups and controls.[99] However, Raphael's research supports the idea that professional help is useful to people who are grieving.[100] This is based on the experiences of two hundred mourners from the Palliative Care Service's bereavement group, this research agrees with that conclusion.[101]

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[98]W.V. William and P.R. Polak, "Follow-up Research in Primary Prevention: A Model of Adjustment in Acute Grief," Journal of Clinical Psychology, 35 (January 1979) p. 35.

[99]David Jones, "The Grief Therapy Project: The Effects of Group Therapy with Bereaved Surviving Spouses on Successful Coping with Grief," Dissertation Abstract International, 39 (June 1979) p. 6121.

[100]Beverly Raphael, "Preventive Intervention with the Recently Bereaved," Archives of General Psychiatry, 34 (December 1977) p. 1450.

[101]Philip Roy, "Group Support for the Recently Bereaved, " Health and Social Work (July 1983) p. 231.

CHAPTER III

METHODOLOGY

A cross-sectional survey is research data that is collected at one point in time. The cross-sectional survey was the design used to assess how the dependent variable; psychosocial adjustment, was affected by the independent variables; race, age, marital status, income, educational level, family support, grief reactions and families' decisions to join a support group.

Setting

SHARE (Source of Helping,Airing and Resolving Experiences) is a support group for families who have experienced an infant death. The participants in this group were members of SHARE and attended monthly support meetings at two sites, the Link Counseling Center in Sandy Springs, Georgia and Piedmont Hospital in Atlanta, Georgia.

SHARE was started in 1985 to assist bereaved families. It is an open group in which members can enter at any time. The group meets once a month for two hours and is supported by a grant through the Link Counseling Center. There are approximately 120 members in the group.

SHARE is a non-profit organization. The goal of the group is to help families to cope with the problems they

encounter after losing an infant. The group sessions consist of topics such as, feeling and experiences associated with grief, its effect on marriage, the extended family, the desire to become pregnant again, and the anniversary of the infant's death. Social activities are provided for members to get to know each other and to celebrate baby reunions for those who have had a successful pregnancy.

Sampling

The sample consists of forty participants of the SHARE group. The sample was randomly selected from a list of names and addresses of the participants. The questionnaires were mailed March 4, 1988 and the participants were asked to respond by March 12, 1988. The survey was mailed to each participant and a cover letter explained the purpose of the study. A total of fifty-five questionnaires were mailed and forty were returned for a 73 percent response.

Instrumentation

The instrument used in this study was a forty-three item questionnaire. The questions were utilized from a study at the Children's Hospital in Denver, Colorado.[102] The study was incomplete at the time my questionnaire was administered. I will provide descriptive data about the

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[102]Narmon Whitfield's Study Neonatal Intensive Care Unit at The Children's Hospital in Denver, Colorado, 1983.

subject e.g., race, age, race marital status, income, educational level, family functioning and support, grief reactions, and families' decision to join a support group.

Statistical Analysis

In analyzing the data, Chi Square and Pearson's r were used. Chi Square was used to test the relationship between two variables. It is based on null hypothesis: the assumption that there is no relationship between the two variables in the total population. Given the observed distribution of values on the two separate variables, the conjoint distribution that would be expected if there were no relationship between the two variables is computed. The result of this operation is a set of expected frequencies for all the cells in the contingency table. A comparison of the expected distribution and distribution of cases actually found in the sample data, will determine the probability of the discovered discrepancy which could have resulted from sample error. The values range from .05 to .01 levels of confidence. Pearson's r determines the strength of the relationship between the variables.

CHAPTER IV

RESULTS AND FINDINGS

Results and Discussion

The data collected in the study provided a profile of forty subjects who have experienced an infant death.

Table 1 describes the demographic data tabulated by the frequency and percentage. Thirty-nine (98 percent) of the subjects were white. Their age range was from twenty-five to thirty-one and above.

Thirty-eight (95 percent) were married with an yearly income twenty-two (55 percent), forty thousand dollars or more. In terms of education, sixteen (40 percent) of the subjects had a graduate degree.

TABLE 1

Demographics

Item	Frequency	Percentage
Race		
1. Black	1	3
2. White	39	98
Age		
1. 25-31	12	30
2. Above 31 years	28	70
Marital Status		
1. Married	38	95
2. Divorced	2	5
Income		
1. 16-24,000	3	7
2. 25-30,000	6	15
3. 31-35,000	2	5
4. 36-40,000	7	17
5. 41-Above	22	55
Education		
1. Completed high school	2	5
2. Some college	6	15
3. College degree	12	30
4. Some graduate work	4	10
5. Graduate work	16	40

The nonparametric statistic used in this study are Chi Square and Pearson's r in examining the significance of the relationship between the dependent variable; psychosocial adjustment and the independent variables; race, age marital status, income, family functioning and support, grief reactions and families' decision to join a support group. The data were examined by using tables. Tables 2, 3, and 4

show the mean and standard deviation of family functioning and support, grief reactions and families decision to join a support group.

TABLE 2

Means and Standard Deviation of Family Functioning/Support

Items	Mean	Standard Deviation
1. How has it been since the baby died?	4.250	1.276
2. Do you feel your life is different?	1.000	.000
3. Relationship with husband	1.350	.736
4. Functioning of husband	1.950	.639
5. Relationship with children	3.225	1.025
6. Functioning of children	3.125	1.202
7. Family support	1.725	.816
8. Have you developed any relationships	1.075	.267
9. Who has been most helpful?	1.725	.554

TABLE 3

Means and Standard Deviation
of Grief Reactions

Items	Means	Standard Deviation
1. Times felt sad or depressed	2.200	.687
2. Had problems sleeping	2.300	.758
3. Problems eating	2.125	.883
4. Dreaming	2.350	1.167
5. Find self thinking about infant	2.750	.981
6. Were you irritated?	2.025	.620
7. Thoughts about cause of infant death	2.900	1.317
8. Have you felt angry?	1.550	.597
9. Crying	1.000	.000

TABLE 4

Means and Standard Deviation of Support Group

Items	Means	Standard Deviation
1. Source of referral to SHARE	4.575	1.615
2. Frequency of attendance to SHARE	1.425	1.217
3. Meetings of attendance	1.125	.404
4. Communicate with SHARE by phone	1.050	.221
5. Duration before joining group	2.025	.920
6. SHARE has been supportive	1.000	.000
7. SHARE provided emotional support	1.000	.000

HYPOTHESIS 1: There is no significant relationship between the psychosocial adjustment and age at the .05 level.

The result of statistical analysis from the cross tabulation showed Chi Square (x^2)=15.75, degree of freedom (df)=2 and p>0.005 level. A p value is the probability of obtaining a value of the test statistic as extreme as or more extreme, in the appropriate direction than actually obtained, given that the tested null hypothesis is true. It is also the smallest level of significance at which a null hypothesis can be rejected.

As a result, the null hypothesis is rejected and the research hypothesis is accepted; therefore it is a significant relationship between age and the psychosocial adjustment of families experiencing an infant death. Findings from the review of literature also have shown that age does not affect how bereaved families deal with grief. Videka-Sherman and Lieberman found that bereaved parents were highly distressed on mental health indicators such as depression, anxiety, somatic symptom, self-esteem, and a sense of control based on age. The author believes that maturity has a lot to do with how a family deals with death, thus age is a factor associated with the psychosocial adjustment.

HYPOTHESIS 2: There is no significant relationship between psychosocial adjustment and marital status at the .05 level.

From the result of the contingency table analysis, x^2=3.90, df=2, p<0.005. Thus, we accept the null hypothesis

and reject the research hypothesis that there is no significant relationship between the psychosocial adjustment and marital status.

According to the research findings in the literature there is a relationship between the psychosocial adjustment and marital status. The marital relationship is particularly vulnerable after a child dies. Through the study done by Schiff indicated that the divorce rate of bereaved parents approached the 80 percent level. Nixon and Pearson's study also indicated that the separation rate was 24 percent in parents who had miscarriages and zero percent in parents who nearly had a miscarriage.

The marital status does not indicate or show any significant relationship to the psychosocial adjustment, perhaps because the participants are mature individuals who have been exposed to functioning of emotional problems independently.

HYPOTHESIS 3: There is no significant relationship between the psychosocial adjustment and income at the .05 level.

To test this hypothesis, the cross tabulation was performed using the SPSSX batch system to determine the relationship between psychosocial adjustment and income. The result of the statistical analysis from the cross tabulation showed Pearson's r (r)=0.74069, df=8, $p<0.005$. Thus, we reject the null hypothesis and accept the research hypothesis that there is a relationship between income and

psychosocial adjustment. Roskin's study investigated the effect of income on the family during the bereavement period. His study concluded that less well-to-do parents were more vulnerable to higher levels of distress and income is related to the distress over a five year period after the child's death.

HYPOTHESIS 4: There is no significant relationship between the psychosocial adjustment and education.

The cross tabulation was performed to determine the relationship between psychosocial adjustment and education. The result of the statistical analysis from the cross tabulation showed $x^2=56.06$, $df=8$, and $p<0.005$. Thus, the null hypothesis is rejected, therefore, there is a significant relationship between the psychosocial adjustment and education.

From the review of the literature, research findings, Videka-Sherman indicated how educational attainment was related to the psychosocial adjustment of the family.

Education is a sum total that one acquires in a defined environment. These experiences are very vital on one's ability to adjust through various situations.

HYPOTHESIS 5: There is no significant relationship between the psychosocial adjustment and family support.

To test the hypothesis, Pearson's r was computed using the SPSSX batch system to determine the relationship between the psychosocial adjustment and family support. The result

of the statistical analysis from the cross tabulation showed $r=0.78494$, $df=4$, $p<0.005$. Thus, we reject the null hypothesis and accept the research hypothesis that there is a significant relationship between psychosocial adjustment and family support.

Finding from the literature agrees with the conclusion. Several researchers have noted that parents provide important support to one another after the death of an infant. Research finding suggested that when a child dies there are several coping strategies that a parent can use to promote personal adjustment. These include, having available and using the support of others, particularly one's spouse and extended family members. Roskin stated that parents who have support may experience a more positive psychosocial adjustment before and after the death of the child.

Moreover, since the families are involved in SHARE and have the support of one another, one may conclude that family support is a major variable in their psychosocial adjustment.

CHAPTER V

CONCLUSION AND IMPLICATIONS

The unexpected death of an infant can be a devastating experience for a family. It is believed that a death exerts inordinate stress on the family, that can cause a dysfunction in the family.

This leads to the research question. Does the death of an infant affect the psychosocial adjustment of the family? This question was answered by looking at five variables: age, income, educational level and family support and how they are related to the psychosocial adjustment of the family. This study showed that age, education and family support has an impact on the psychosocial adjustment of the family.

This study has several implications for future research. First, it is the author's opinion that this study should be explained in terms of examining children's adjustment to the death of a sibling, support for the family unit, and crisis intervention.

There was only one Black in the sample, future research needs to determine why minorities are underrepresented in a support group such as SHARE. This gives validity to several hypothesis that can be further tested such as: (1) What do

Black families and other minorities do to cope with death? (2) Are resources made available to minorities who have experienced a death?

The data from this study is influenced by age education, income and family support. Are these families able to adjust because of maturity, is education a major factor and is income important in their psychosocial adjustment? Finally is family support the major factor in the overall adjustment of the bereaved family and their acceptance of the death of an infant?

Implications for Social Works

The study has several implications for social work interventions. As stated in the available literature, social workers can assist families who have experienced an infant death by being a support person, consultant, educator, and advocate for the family during the time of crisis. It is necessary that social workers provide counseling services and crisis intervention to families before the mother's release from the hospital following an infant death. Social workers should implement support groups in Pediatrics and the Neonatal Intensive Care Units in the hospital, to make resources accessible to the family. On going follow-up should be done for the purpose of evaluating the family's psychosocial adjustment following the death of the infant.

Finally, families who are in crisis are at a point where social work treatment and intervention may be effective in enabling the family to adjust during bereavement. The family's environment, inclusive of the extended family, friends, co-workers, church and society are all factors in assisting the family. In addition, social workers need to intervene in all of these social systems if the bereaved family is to have a positive psychosocial adjustment. Therefore, social workers need to develop programs and provide social work interventions to families during their unexpected crisis.

Consequently, I strongly recommend that social services provide support in the Pediatric and Neonatal Intensive Care Units, and these services should be inclusive for all ethnic and socio-economic levels.

APPENDIX A

P.O. Box 55
Atlanta University
Atlanta, Georgia 30314
March 4, 1988

Ms. Smith
20 Oakdale Dr., S.W.
Atlanta, Georgia 30335

Dear Ms. Smith:

I am Valerie Nettles, a student in the masters program at Atlanta University. My area of study is social work and I am completing my requirements by conducting a study about the impact of infant death on the family. The purpose of the study is to examine the psychological and social adjustment of families who have experienced an infant death. This study will help social workers to be aware of the need to assist families who have experienced an infant death, which I have observed in the support group SHARE.

Your response to this questionnaire will aide in my success on gathering necessary facts in order to implement programs in working with families such as yourself.

Enclosed is a stamped self-addressed envelope. Due to the limited time of conducting this study, will you please respond by March 12, 1988. Thank you in advance for your cooperation.

Sincerely yours,

Valerie Nettles

APPENDIX B

QUESTIONNAIRE

Please answer the following questions by placing a X in the box.

Race

[ ] White
[ ] Black
[ ] Mexican or Spanish American
[ ] Other

Age

[ ] Under 18
[ ] 19-24
[ ] 25-30
[ ] 31-above

Marital Status

[ ] Single
[ ] Married
[ ] Separated
[ ] Divorced
[ ] Widowed

Income

[ ] Less than 10,000
[ ] 16,000-24,000
[ ] 25,000-30,000
[ ] 31,000-35,000
[ ] 36,000-40,000
[ ] 41,000-above

Education

[ ] Less than high school
[ ] Completed high school
[ ] Some college
[ ] College degree
[ ] Some graduate school
[ ] Graduate degree

The following questions refer to the first month after you lost your baby.

Family Functioning/Support

1. How has it been since your baby died?

[ ] Okay (reason)
[ ] Went back to work
[ ] Religious beliefs
[ ] Pregnant again
[ ] Somewhat difficult
[ ] Very difficult

2. Do you feel your life is different now?

[ ] yes [ ] no

3. How is your relationship with your husband?

[ ] Much closer
[ ] No change
[ ] Marital difficulty
[ ] Not applicable

4. How is your husband functioning?

[ ] Accept well
[ ] Some difficulty or avoid subject
[ ] Major effect on functioning
[ ] Not applicable

5. How is your relationship with your children?

[ ] No change
[ ] Impatient/ resentment
[ ] Love appreciates more
[ ] Not applicable

6. How are your children functioning?

[ ] Accepts well
[ ] Some difficulty or avoids subject
[ ] Major effect on functioning
[ ] Not applicable

7. How is your relationship with your extended family?

[] Closer; new empathy or understanding
[] No change
[] Increase difficulties

8. Have you developed any new relationships?

[] Yes [] No
[] Social & Community involvement, i.e., (friends, church, social worker, doctor, new friends at work)
[] Friend with loss in common
[] Met people at work but, really no friends
[] We have moved and made new fiends

9. Who has been most helpful?

[] Husband/father of child
[] Maternal grandmother
[] Support group/SHARE
[] No one
[] Other

10. Grieving questions: We know after a death you may have a difficult time. People often have trouble sleeping, feeling sad, etc.

a) After ___ died, were there times felt sad or depressed?

[] No depressed
[] Occasionally depressed
[] Depressed at least half the time
[] All the time

b) Did you have any problems sleeping?

[] No trouble
[] Occasional trouble
[] Trouble at least half the time
[] All the time

c) Did you have any problems eating?

[ ] No problems
[ ] Eat more
[ ] Eat less
[ ] All the time

d) Did you find yourself dreaming about ___?

[ ] Yes [ ] No
Occasionally, but positive dreams
[ ] Mixed dreams
[ ] Occasional nightmares and/or bad dreams
[ ] Frequent nightmares and/or bad dreams

e) Did you find yourself thinking about ____?

[ ] Yes [ ] No
[ ] Occasional, positive memories or fantasies
[ ] Mixed thoughts but not pre-occupied in the day
[ ] Pre-occupied at times with thoughts
[ ] Intrusive thoughts

f) After____ died, were you irritable?

[ ] Not irritable
[ ] Somewhat irritable
[ ] Irritable at least half the time

g) Did you have any thoughts what may have caused your baby's problems?

[ ] Yes [ ] No
[ ] Specific identifiable medical cause
[ ] Some guilt present but it is unclear if there's a direct relationship
[ ] Moderate amount of guilt present which is unrealistic given the medical cause
[ ] Blames others for infant's death inappropriately
[ ] Blames others for infant's death appropriately

h) Have you felt angry?

[ ] Yes [ ] No
[ ] Some anger or disappointment
[ ] Moderate anger, but was justified given to the circumstance
[ ] Pervasive anger

11. Have you experienced any of the following after the baby died?

a) Episodes of crying [ ] Yes [ ] No
b) Praying for baby [ ] Yes [ ] No
c) Feeling of depression [ ] Yes [ ] No
d) Feeling of disbelief about what happened [ ] Yes [ ] No
e) Wanting to be left alone [ ] Yes [ ] No

12. Thought about present pregnancy

[ ] Wants to try to get pregnant again/now
[ ] Wants to try to get pregnant again/future
[ ] Never want to be pregnant again
[ ] Mixed feelings about getting pregnant
[ ] Probably do not want to get pregnant again
[ ] Not applicable

13. Who was most supportive to you in the hospital after the death of the baby?

[ ] Social Worker [ ] chaplain
[ ] Doctor [ ] Nurse
[ ] Family member(s) what relation

14. Did you hold your baby?

[ ] Prior to baby's death
[ ] After the baby died

15. Who was with you when the baby died?

[] Social Worker [] Chaplain
[] Doctor [] Nurse
[] Family member (s) [] alone
what relation _____

16. Did you get a picture of the baby?

[] No, but picture was taken
[] No, but wish I had a picture
[] Yes, picture was helpful
[] Yes, picture was not helpful

17. Did you name the baby?

[] Yes [] No

18. Was there an autopsy done?

[] Yes, found out results [] No
[] Yes, did not find out results

19. Who contacted you about the results?

[] Social Worker [] No one
[] Doctor [] Not applicable

20. Did the autopsy help you to understand why the baby died?

[] Yes [] No

21. Who explained different choices available to families concerning burial/funeral?

[] Social Worker [] Nurse
[] Funeral Director [] Doctor
[] Chaplain [] No one
[] Not applicable

22. Who referred you to the support group, SHARE?

[] Social Worker
[] Doctor
[] Person/friend with same experience
[] Chaplain
[] Nurse
[] Self
[] Newspaper

23. How often do you attend SHARE?

[] Every month
[] Every 2 months
[] Every 3 months
[] Not applicable

24. What meeting do you attend?

[] Couples
[] Women

25. Do you communicate with SHARE by phone?

[] Yes
[] No

26. How soon did you join SHARE after the death of the baby?

[] Less than 3 weeks
[] 1-6 months
[] 7 months
[] 2-3 years
[] 4 years
[] 4 years or more

27. Has the support group, SHARE been helpful?

[] Yes, help me through the grieving process
[] No, has not helped me through the grieving process

28. Did SHARE provide emotional support outside the grieving process?

[] Yes
[] No

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